STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E245	A. BUILDING 00 B. WING	07/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST AUGUSTINE HOME FOR THE AGED	2345 W 86TH ST INDIANAPOLIS, IN 46260

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F000000	This visit was for Recertification and State Licensure Survey. Survey dates: July 7, 8, 9, 10, 11 & 14, 2014 Facility number: 000389 Provider number: 15E245 AIM number: 100288920 Survey team: Gloria Bond, RN, Team Coordinator Michelle Hosteter, RN Sandra Nolder, RN Janet Stanton, RN Census bed type: NF 40 Residential 22 Total 62 Census payor type: Medicaid 34 Other 28 Total 62 Residential Sample: 7 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality Review was completed by	F000000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Tammy Alley RN on July 22, 2014.			
F000241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Based on observation and interview, the facility staff failed to knock before entering a resident's room for 2 of 2 observations for dignity. (Resident #40) Findings include: 1. On 7/9/14 at 2:26 P.M., a dressing change was being observed on Resident #40. During the dressing change two unidentified CNA's knocked on Resident #40's door on separate occasions, then were observed walking into the resident's room without asking if they could enter the room. LPN #1 and CNA #14, who were with the resident at that time failed to inform the two CNA's that resident care was being provided. The CNA's looked around the room, then walked back out of the resident's room. On 7/10/14 at 2:20 P.M., LPN #13 was observed entering Resident #40's room without knocking on the door before she entered the room.	F000241	In order to preserve resident dignity and privacy, we will be conducting an Inservice for all staff that have access to residents, including: Dietary; Nursing; Activities; Maintenance; Social Services; Housekeeping. We will have hand outs on the Resident Rights that all residents have the right to be treated with Dignity and Respect of Individuality including their right to privacy by knocking on their doors and gaining permission to enter before entering. This also includes that staff giving care to the resident inform those requesting to enter to come at another time. Signs will be placed in various places for employees to be reminded of the requirement to knock before entering. Floor nurses will monitor their respective units sporadically 2 times a week, x 2 weeks; then q month x 2 months and record observations in a log. Social Services will also interview no less than two random residents 2 x a week, x 2 weeks; then q month x 2 months to ensure that staff not entering	08/13/2014

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	During an interview at that time, LPN #13 indicated she had forgotten to knock on Resident #40's door before she entered the resident's room. 2. On 7/11/14 at 12:15 P.M., a resident who stated they did not want to be identified, indicated there are staff during the day hours that will walk right into the room without knocking. The resident indicated it bothered them because you never knew when someone might just walk in. 3.1-3(p)(4) 3.1-3(t)		without knocking. We will have monitoring flow sheets. Any staff not in compliance with this regulation will be disciplined according to procedures of facility.	
F000278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the			

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	accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. Based on observation, interview and record review, the facility failed to ensure the MDS (Minimum Data Set) assessment accurately reflected a resident's status, related to dental, skin, and ROM (Range of Motion) issues; for 3 of 22 residents reviewed. (Residents #14, #35, and #40) Findings include: 1. The closed clinical record for Resident #14 was reviewed on 7/9/14 at 2:44 P.M. Diagnoses included, but were not limited to, hypertension, transient cerebral ischemia, stricture of artery, depressive disorder, and hypothyroidism, The resident was originally admitted to the health care section of the facility on 2/14/14, following a fall in her	F000278	To ensure assessment accuracy for the MDS, the following procedures will be implemented: MDS Coordinator is now a member of wound team which meets every week to ensure that wound sheets are filled out completely and accurately. We will also be doing visual checks during rounds and measuring wounds to determine progress of healing or lack thereof. CNA's will be educated to notify nurses immediately upon finding any red areas found on any resident, during all CNA inservice. All residents that present with a pressure ulcer, stage I-IV, possible deep tissue injury, venous ulcers, arterial ulcers, or diabetic ulcers will have a wound sheet created by nurse that assesses new area. This nurse will also notify MD of new area and receive treatment orders. Nurses will follow policy and	08/13/2014

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	independent apartment that resulted in a fractured hip. She was discharged again to hospital on 2/27/14 for a gastrointestinal bleed from a perforated duodenal ulcer, and was readmitted to the facility on 3/2/14. She expired on 3/7/14 at 4:35 P.M. A progress note, dated 2/14/14, indicated "Arrived on unit... Skin assessment shows bruises on arms and legs post IV and fall. Bottom is red." There were no other progress notes from 2/14 to discharge on 2/27/14 related to the red bottom or other skin issues. On 2/21/14, the physician gave an order for "Duoderm to coccyx, change every 72 hours." DuoDerm is an opaque hydrocolloid dressing used to cover and treat superficial, partial, and full thickness pressure ulcers, other dermal ulcers, partial thickness burns and donor sites, and eczema. A "Skin Assessment," dated 2/14/14 and completed by a unit nurse, indicated "Home from the hospital this eve. Has bruises on legs and arms post IV and fall. Bottom red." There was no additional descriptive information related to the red bottom. A "Skin Assessment," dated 3/2/14 and		procedure for skin care and skin care of decubiti. Skin assessments will be done on admission, quarterly, and upon finding a new skin issue by nurse working the unit. The medical records consultant will monitor MDS's during her visits for accuracy. She will monitor no less than 2 MDS's randomly for accuracy during her visits on an ongoing basis. Nurses will be inserviced and policies implemented by 8/13/14. MDS Coordinator was aware that resident # 35 had broken teeth due to review of chart including dental visits and oral assessment, but on last annual assessment inadvertently missed checking "obvious or likely cavity or natural broken teeth". MDS Coordinator will be more diligent with data entry to minimize oversight errors. Medical records will conduct audits for accuracy as described above. In regards to resident #40, MDS Coordinator received a worksheet from Restorative CNA #10 for assessment period 5/22/14-5/28/14 stating that resident did not have any ROM impairments/functional limitations in upper or lower extremities. This worksheet was marked incorrectly and MDS Coordinator failed to recognize error. Restorative CNA is responsible for doing ROM testing/functional limitations and reporting to MDS Coordinator via worksheet for all	

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	completed by the same unit nurse, indicated the resident had no pressure ulcers, with pale, normal/warm, and dry skin. There was no additional descriptive information related to the status of the resident's skin. The March, 2014 MAR (Medication Administration Record) had nurse initials documenting the DuoDerm was applied on 3/1 and 3/5/14. The Admission MDS was completed on 3/3/14, with an Assessment Reference Date (ARD--the last day of the observation period) of 2/27/14. Section M, for assessment of the skin, covered a time frame of 7 days prior to the ARD. For Resident #14, the time period would have been from 2/20 to 2/27/14. The coding at this section indicated the resident was at risk for developing a pressure ulcer, had no current unhealed pressure ulcer at Stage 1 or higher, had a surgical wound and skin tears. There was no identification of any skin issue that would have required a DuoDerm skin treatment beginning on 2/21/14. In an interview on 7/11/14 at 9:00 A.M., the MDS Coordinator indicated she did not see or examine the resident's bottom upon admission (2/14/14), and none of the nurses had said anything to her about the resident's "red bottom." She took the		MDS's due. MDS Coordinator will speak with restorative CNA and re-educate per RAI manual on how to correctly access ROM limitations and double check resident limitations prior to placing on MDS to ensure accuracy of MDS data. This will be completed by 8/13/14.	

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	order for the Duoderm on 2/21/14, and saw the area either later the same day or the next day. She indicated she thought the coccyx area may "just have been excoriated," but she could not recall for sure. She indicated the nurses completing the computer "Skin Assessment" forms should use Section 1 to describe any areas of a resident's body where the skin was altered (rashes, scars, skin tears, abrasions, bruises, surgical incisions, etc.) The MDS Coordinator indicated a barrier cream was the treatment of choice for skin excoriation. 2. On 7/08/14 and 1:07 P.M., Resident #35 was observed sitting in a wheelchair in the TV lounge. When she was asked how her lunch was, and she responded that it was good. She was observed to have three upper front teeth, with several bottom teeth worn and/or broken off just above gum line. Some of the broken teeth were gray in color. She indicated she had no problem eating. The clinical record for Resident #35 was reviewed on 7/9/14 at 9:27 A.M. Diagnoses included, but were not limited to, hypertension, anemia, peripheral neuropathy, history of open fracture femur neck/closed fracture of femur shaft, vascular dementia, osteoarthritis, depressive disorder, and senile dementia-			

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	-Alzheimer's type. An "Oral Evaluation/Recommended Treatment" form, completed by a consultant dentist on 4/3/13, indicated "Sever roots--few teeth; soft tissue within normal limits." The remainder of the form was blank except for the consultant's signature and date. An "Oral Evaluation/Recommended Treatment" form, dated 10/2/13, indicated "Natural teeth; soft tissue within normal limits; upper tooth # 7,8,9, and 11; bottom tooth #31, 27, 26, 24, 23, 22, 21, and 18." The remainder of the form was blank. The "Oral Evaluation/Recommended Treatment" Form dated 4/2/14, indicated "Soft tissue within normal limits; current remaining teeth--upper #7, 8, 9, with #11--root; lower #17 and 32, with roots #27, 26, 25, 24, 23, 22." There were no recommendations for other treatment. "Weekly/Monthly/Quarterly Nursing Summary" assessments indicated the following: 9/12/13--"Plaque or debris in localized areas; has own teeth" 11/19/13--"Clean with no debris; Has own teeth." 12/2/13--"Clean with no debris; Broken			

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	or loosely fitted dentures." 5/2/14--"Teeth/Denture Bearing Area--Plaque or debris in localized area (between teeth if present); Has own teeth." The Annual MDS assessment, dated 9/17/13, indicated the resident had a BIMS (Brief Interview for Mental Status) of "02" (with 0-7 indicating severe cognitive impairment). Section L (for Dental status) indicated the resident had no dental issues. Part D, listing "obvious or likely cavity or broken natural teeth" was not checked. A Quarterly MDS assessment, dated 5/13/14, indicated the resident had a BIMS of 01. Section L (Dental) had no check marks, including Part D, for "obvious or likely cavity or broken natural teeth." In an interview on 7/9/14 at 2:10 P.M., the MDS Coordinator indicated she believed Resident #35 may have some broken teeth, and was aware that the consultant dentist had examined the resident. She indicated she had missed coding it on the annual MDS assessment. 3. On 7/8/14 at 10:21 A.M., Resident #40 was observed to have bilateral hand contractures and bilateral foot drop. The resident's contracted left hand was			

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	observed to have a lamb's wool splint. During an interview on 7/7/14 at 3:16 P.M., LPN # 9 indicated Resident #40 had bilateral hand contractures and bilateral foot drop. She indicated the resident had a left palm splint and received rehabilitation services for her contractures. Resident #40's record was reviewed on 7/9/14 at 4:00 P.M. Diagnosis included, but were not limited to, vascular dementia with delusions, severe progressive dementia, legally blind, spinal stenosis, contractures, osteoarthritis, stage 4 pressure ulcer to coccyx and incontinence. The Quarterly MDS (Minimum Data Set) assessment dated 5/28/14, indicated the resident's functional limitations in her range of motion (ROM) to the upper and lower extremities indicated no impairment was present. The Quarterly MDS assessment dated 5/28/14, lacked documentation that indicated the resident had contractures to her bilateral hands and foot drop to her bilateral feet. The resident's July 2014 Treatment Administration Record recap (recapitulation) included, but was not			

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	limited to the following: 3/1/14--PROM (Passive Range of Motion) to all extremities three times a week. During an interview on 7/11/14 at 1:07 P.M., Restorative Aide #10 indicated she provided range of motion services to this resident's bilateral upper and lower extremities. She indicated she stretched the resident's extremities three to five times per week for 10 minutes each time. She indicated she had been providing these services to this resident for six months for her feet and and since she was admitted for the resident's bilateral arms and legs. During an interview on 7/11/14 at 4:15 P.M., the MDS Coordinator indicated the Quarterly MDS assessment dated 5/28/14, indicated Resident #40 had no impairments for the upper or lower extremities. She indicated she received the information for the functional limitations in the resident's ROM from Rehabilitation Aide #10. The MDS Coordinator indicated the information for the resident's impairments for her upper and lower extremities for the Quarterly MDS assessment dated 5/28/14, was incorrect information. 3.1-31(d)			

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F000282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, interview and record review, the facility failed to ensure care plans were followed for pain and pressure ulcers for 1 of 22 residents reviewed for care plans and failed to follow Physicians orders for pain, pressure ulcers and catheter care for 2 of 22 residents reviewed for Physicians orders. (Resident's #12, # 40 and # 8) Findings include: 1. On 7/9/14 at 9:15 A.M., Resident #12 was observed lying on her left side and her right heel was lying on the mattress. On 7/9/14 at 10:00 A.M., the resident was observed lying on her left side and her right heel was lying on the mattress. On 7/9/14 at 10:50 A.M., Activities Assistant #15 entered the resident's room, spoke to her and turned her television on	F000282	To ensure care plans are carried out by Qualified persons: The facility will have an Inservice for all Nursing personnel. We will have hand outs on the facility Policy and Procedure for 1. Peri-Care 2. Catheter Care 3. Pain Management 4. Skin Care, Maintenance 5. Skin Care, Decubiti. We will go over at length the correct way to do peri-care. Also the policy has been updated for CNA's to do Cath-care. We will demonstrate and train all Aides in the proper technique for Peri and Cath care. For identification of residents at risk of pressure ulcers and or chronic pain, we will address the potential residents at the Residents at Risk meetings that we have every week. those residents at risk for skin breakdown by following our Skin Care, Maintenance policy. Those at risk for chronic pain we will follow our Pain management policy. This includes assessing residents for pain on a numerical scale 1-10 when complaining of	08/13/2014

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	for her. The resident was observed lying on her left side with her right heel was lying on the mattress. On 7/9/14 at 11:00 A.M., the resident was observed lying on her left side and her right heel was lying on the mattress. On 7/9/14 at 12:30 P.M., the resident was lying on her left side and her right heel was lying on the mattress. On 7/10/14 at 3:26 P.M., Resident #12's right buttock area was observed during a dressing change. The resident's right buttock was observed with an open area with 15% red, 35% yellowish/white slough (stringy, moist, dead and nonvascular tissue in the process of separating from the viable portions of the body) and 50% blackish/brown eschar (thick, leathery and dead tissue that has lost it's own usual properties and biological activity) tissue to the wound bed. Resident #12's record was reviewed on 7/9/14 at 9:52 A.M. Diagnoses included, but were not limited to, decubitus ulcer to the right buttock area, osteoarthrosis, osteoarthritis of the neck, deep vein thrombosis of the right calf and Alzheimer's dementia.		pain, or if exhibiting signs of pain. Appropriate intervention will be implemented either non medicinal or medicinal. The resident will be assessed before and after 45 minutes to ensure effectiveness. If not effective the MD may be contacted. Pain Flow sheets will be filled out. These will be monitored by our Quality Assurance Nurse, q week x 4 weeks then q month x 2 months. Nurses are required to start a Wound Sheet for a Stage I-IV wounds for possible deep tissue injury, venous and arterial wounds, and diabetic wounds. They will measure and document findings every week. If there is any deterioration the MD will be contacted for possible new treatment orders. The wound team will also be updated on deterioration or improvement by staff nurses and call MD when needed. Aides are to turn every 2 hours any resident with a pressure ulcer on their buttocks; coccyx. They are to document on the turn sheet q 2 hours, as ordered in the residents care plan. Residents with orders to float heels must have their heels floated at all times while in bed. Resident with an order to not be in a position >30 degrees while in bed, unless being fed, is the Aides responsibility to lower the bed 30 min.after feeding the resident. Nurses on duty will be responsible for overseeing residents with the following	

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	The resident's July 2014, Treatment Administration Record recap (Recapitulation) included, but were not limited to the following orders: 1/30/14--Float heels while in bed. 7/3/14--Turn every two hours side to side only for decubitus ulcer. The resident had a Care Plan dated 7/10/14, that addressed the problem she had a Stage III pressure ulcer to her right buttock area. The interventions indicated "7/10/14--Turn resident side to side to maintain pressure off of that area...." During an interview on 7/9/14 at 12:30 P.M., CNA #7 indicated this resident was her responsibility to provide care to for the shift and she was turned at 9:00 A.M. She indicated she had not turned her as of yet, because she had not had time, because she had been busy taking care of her other residents. CNA #7 indicated the back up plan when she got behind in her work load was to ask one of the other CNA's to help her if they were not busy. She indicated if the other CNA's were busy, then she was to call one of her supervisors to come and help her. She indicated she had not asked anyone for help. She had just tried to "catch up." During an interview on 7/9/14 at 1:50 P.M., LPN #1 indicated the resident's		orders: turn q 2 hours; float heels when in bed; and lowering bed to 30 degree position 30 minutes after meals. This monitoring will be conducted by the nurse on duty; they will check 1 times every shift x 3 weeks, and then once daily for 1 month to ensure these care plan orders are being carried out. They will have monitoring flow sheets. If an Aide is non-compliant with following the care plan orders he/she will be disciplined according to our procedures. Aide and nurses will be reminded that the care plan book is in the chart rooms and can be reviewed at any time.Family requested to not have resident sent toa pain specialist.	

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	right heel "was a little pink, but it was not mushy" She indicated she had not realized that the resident had not been turned for three and a half hours. During an interview on 7/9/14 at 5:50 P.M., the DoN (Director of Nursing) indicated the residents were to be turned every two hours. 2a. On 7/9/14 at 11:35 A.M., while CNA #7 was observed giving Resident #40 peri care, she was not observed giving the resident catheter care. The resident's Quarterly MDS (Minimum Data Set) assessment dated 5/28/14, indicated her Cognitive Skills for Daily Decision Making was moderately impaired, which indicated her decisions were poor and cues and supervision were required. The resident's functional status indicated she was totally dependent with two person physical assistance needed for bathing. The resident had a July 2014, Treatment Administration Record recap (recapitulation) included, but was not limited to the following: 1/30/14--Catheter care every shift. She indicated she did not do catheter care because "I have not performed catheter			

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	care in the 30 years that I have been a CNA because I was not taught to do that." She indicated the nurses at this facility have told the CNA's "Not to mess with the catheters because we will pull on them and that is why they leak." She indicated she thought the nurses did the catheter care. During an interview on 7/9/14 at 2:45 P.M., LPN #1 indicated the CNA's were to provide catheter care for residents during baths and with incontinent episodes. During an interview on 7/9/14 at 4:00 P.M., the DoN (Director of Nursing) indicated that "Nursing Personnel" on the "Urinary Catheter Care Policy and Procedure" indicated the Nurses or the CNA's either one could provide catheter care to the residents with catheters. During an interview on 7/9/14 at 5:50 P.M., the DoN indicated this resident should have had catheter care during her bath and during any incontinent care by all nursing staff. 2b. On 7/9/14 at 9:50 A.M., Resident #40 was observed lying on her back with a pillow propped at the right side of her back and she was sitting at a 90 degree angle. The resident's bilateral heels were			

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	lying on the mattress. On 7/9/14 at 10:36 A.M., LPN #1 went into the resident's room and obtained her vital signs. The resident was observed lying on her back with a pillow propped at the right side of her back and she was sitting at a 90 degree angle. The resident's bilateral heels were lying on the mattress. On 7/9/14 at 10:40 A.M., the Activities Assistant #15 went into the resident's room and said "Good Morning" to her then left the room. The resident was observed lying on her back with a pillow propped at the right side of her back and she was sitting at a 90 degree angle. The resident's bilateral heels were lying on the mattress. On 7/9/14 at 11:35 A.M., CNA #7 was observed entering the resident's room to give her a bath. The resident was observed lying on her back with a pillow propped at the right side of her back and she was sitting at a 90 degree angle. The resident's bilateral heels were lying on the mattress. The resident's bilateral heels were observed to be red and felt mushy. The resident's July 2014, Treatment Administration Record recap (Recapitulation) included, but were not			

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	limited to, the following orders: No order date--Float heels A "Discharge Instruction Details" sheet indicated, Wound Clinic orders dated 4/2/14, indicated "...offload heels-no pressure to heels...Do not elevate HOB (head of bed) over 30 degrees and limit time spent up in w/c (wheelchair) to decrease friction and pressure to wounded areas...." The resident had a Care Plan with a revision date of 5/9/14, that addressed the problem she had a Stage IV pressure ulcer to her coccyx area. Interventions indicated "...3/22/13--Treatment as ordered...5/16/13--Reposition resident to maintain pressure off of area where ulcer is present...." During an interview on 7/9/14 at 11:35 A.M., CNA #7 indicated the resident was lying on her back and she placed a pillow on the right side of her to relieve some of the pressure off her bottom when she was lying on her back. She indicated the resident's heels were to be floated off the bed with pillows and the resident's heels were lying on the mattress. During an interview on 7/11/14 at 4:00 P.M., the DoN (Director of Nursing) indicated the HOB should not have been			

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	elevated in the 90 degree position. 3. On 7/9/14 at 11:00 A.M., the record review for Resident #8 was completed. Diagnoses included, but were not limited to chronic pain, prostate problems, high cholesterol, high blood pressure and Parkinson's. The resident MDS (Minimum Data Set) assessment dated 4/9/14, indicated the resident was was not cognitively impaired. The MDS also indicated the resident indicated he had constant very severe pain that affected his ability to sleep and his ability to perform activities of daily living. The Care Plan dated 4/10/14 indicated potential for pain related to multiple back surgeries, sciatica, benign prostatic hypertrophy, ear pain, history of eye pain. The Care Plan goal was for the resident will verbalize decrease in pain on 1-10 scale within 45 minutes of pain medication administration. Interventions: refer resident to pain clinic/specialized pain doctor for further intervention for pain (4/14/14) Assess residents pain level before and after pain medication administration, administer scheduled pain medication as ordered, offer resident pain medication before any strenuous activity, offer as needed (PRN) pain medication as appropriate for breakthrough pain,			

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	monitor resident for non verbal signs and symptoms of pain, facial grimacing, moaning, rocking, restlessness, remind resident to ask for pain medication prior to pain becoming severe, encourage non-medical methods to assist with pain control...i.e...relaxation, imagery, music, and notify physician if current pain control regimen was not effective. The pain assessment dated 6/25/14, indicated further assessment was needed. The pain assessment indicated the resident had lumbago, numerous back surgeries and that resident stated pain in back and buttocks at times aching and at times sharp. The pain was increased by ADL (Activities of Daily Living) and strenuous activity. There was a physician order dated 4/1/14 for Tylenol 325 milligrams every 6 hours as needed for pain. On 7/8/14 at 11:19 A.M., Resident #8 indicated that he had a lot of right hip and back/leg pain. He indicated on a scale of 1 to 10, 10 being the worse pain, he had a pain level of a 5 after he takes the Tylenol the nurses usually gave him. He indicated he would have preferred a pain level of 2. He indicated he had asked the nurse earlier this morning for pain medication and she had told him it wasn't			

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	time yet. On 7/9/14 at 10:45 A.M., the resident indicated his pain was "terrible right now as he had just got done with therapy" He indicated to CNA #11, he did not want to go to mass as he was not feeling well after therapy. The resident indicated he was going to get some pain medication as he had not received any this morning. The Medication Administration Record for July indicated he had received Tylenol 325 milligrams 2 tabs for pain as needed every 6 hours, on 7/6/14 at 10 A.M., 5:00 P.M. and 11:50 P.M. On 7/8/14 at 11:00 A.M. and 5:00 P.M. On 7/9/14, Tylenol was given at 11:30 A.M. and 5:00 P.M. A discharge summary from the hospitalization prior to admission on 3/27/14 indicated, "...The family stated he has had prior admits for narcotic withdrawal. His pain is managed by a pain specialist...." There was no documentation found that a pain specialist had been contacted for a referral. 3.1-35(g)(2)			

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F000309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on observation, interview and record review, the facility failed to provide pain management for 1 of 2 resident reviewed for unrelieved pain. (Residents #8) Findings include: 1. On 7/9/14 at 11:00 A.M., the record review for Resident #8 was completed. Diagnoses included, but were not limited to, chronic pain, prostate problems, high cholesterol, high blood pressure and Parkinson's. The resident MDS (Minimum Data Set) assessment dated 4/9/14, indicated the resident was was not cognitively impaired. The MDS also indicated the resident had constant very severe pain that affected his ability to sleep and his ability to perform activities of daily living. The Care Plan dated 4/10/14 indicated potential for pain related to multiple back	F000309	To ensure all residents with pain and or chronic pain are able to maintain the highestpracticable physical, mental, and psychosocial well being, in accordance with the comprehensive assessment and plan of care. The facility will conductan Inservice with all Nurses to go over our Policy and Procedure for PainManagement. We will use Pain flow sheets to monitor pain levels on a numericalscale of 1-10, and non-verbal assessment. When a resident exhibits non-verbal signs of pain and when a residentsvoices complaints of pain, the nurses will doa pain assessment. The nurses will administer non-medicinal or medication txappropriate to the situation. They will do another numerical pain assessment 45min after medication or non-medicinal treatmentis administered.If still no relief may contact MD. We will assign a Quality Assurance nurse to monitor pain flow sheetsq 2 weeks x 1 month, then q month. Nurses who are not following our	08/13/2014

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	surgeries, sciatica, benign prostatic hypertrophy, ear pain, history of eye pain. The Care Plan goal was for the resident will verbalize decrease in pain on 1-10 scale within 45 minutes of pain medication administration. Interventions: refer resident to pain clinic/specialized pain doctor for further intervention for pain (4/14/14) Assess residents pain level before and after pain medication administration, administer scheduled pain medication as ordered, offer resident pain medication before any strenuous activity, offer as needed (PRN) pain medication as appropriate for breakthrough pain, monitor resident for non verbal signs and symptoms of pain, facial grimacing, moaning, rocking, restlessness, remind resident to ask for pain medication prior to pain becoming severe, encourage non-medical methods to assist with pain control...i.e...relaxation, imagery, music, and notify physician if current pain control regimen was not effective. The resident pain assessment dated 6/25/14 indicated further assessment was needed. The pain assessment indicated the resident had lumbago, numerous back surgeries and that resident stated pain in back and buttocks at times aching and at times sharp. the pain was increased by ADL (Activities of Daily Living) and strenuous activity. The pain was worse		P&P will be disciplined according to our procedures. The Inservice will be conducted August 6 & 8.	

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	in the evening. He indicated the pain was occasional. The nonverbal indicators of pain were grimacing and distorted face, frowning/scowling, wrinkled brow and grunting. Relief of pain received by medications, frequent position changes, medication in use indicated as regimen is Butrans, and Tylenol for PRN Progress notes indicated: "5/27- Resident requested strongest pain pill he could have, was given PRN Tylenol stated he was up all night with the worst pain in his buttocks and that the pain started at A.M. 7:26 A.M., resident started crying and complaining of pain, resident asleep when nurse checked on resident. Stated he did not have pain in the hospital... 5/31- resident requested and was given PRN Tylenol for pain at 2:00 A.M. at 3:30 A.M. and rest of shift requesting medication for pain. Resident was told that no more medicine could be given until 8:00 A.M. but resident continues to request... 7/1-Requested PRN Tylenol at 5:00 P.M. for back pain. 7/2-Requested PRN Tylenol at 5:30 P.M. for back pain. 7/3-Requested PRN Tylenol at 4:30- & 10:30 P.M. for back pain. 7/4-Requested PRN Tylenol at 8:00 P.M.			

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	for back pain. 7/5-Requested PRN Tylenol at 2:00 A.M. & 4:00 P.M. for back pain. 7/6-Requested PRN Tylenol at 5 P.M.& 11:00 P.M. for back pain. 7/7/14: Requested PRN Tylenol at 11:50 P.M. for back pain. 7/8/14: 5 PM Tylenol given for back pain. Resident requested and given PRN Tylenol 325 milligrams for pain at 5 A.M. 7/9/14 lidocaine patch discontinued. 5 PM Tylenol given for back pain...." The Medication Administration Record (MAR) for May 2014, he received Tylenol 325 milligrams 2 tabs at least daily on 5/3, 5/27, 5/28, 5/29, and 5/30. The MAR for June 2014 indicated the resident received PRN Tylenol 325 milligrams at least daily except for June 10th, June 13th-16th, 19th, 23rd, and 27th. He received it twice on 6/3, 6/4 and 6/17. On 7/8/14 at 11:19 A.M., Resident #8 indicated that he tends to have a lot of right hip and back/leg pain. He indicated on a scale of 1 to 10, 10 being the worse pain, he tends to have a pain level of a 5 after he takes the Tylenol the nurses usually give him. The resident indicated he would prefer a pain level of 2. He indicated he asked the nurse earlier this			

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	morning for pain medication and she told him it wasn't time yet. The resident indicated on 7/10/14 at 10:15 A.M., his pain was at an "8" right now, and he felt it doesn't really seem to get better," it goes up and down, and was getting really tired of having it. I don't know if I can even get anything for the pain depending on the schedule and if it is time yet. I have to wait often for the medication. I don't know why my back and buttocks hurt so much, I guess it was from the falls, as I have had a lot." The MAR for 7/10/14 indicated no pain medication had been given. On 7/10/14 at 10:27 A.M., LPN # 12 indicated during interview, the resident had a history of addiction to Lortab so "he is always in the worse pain ever" he will tell you that and then a half hour later he will be asleep. She indicated that the family had told them he had the addiction and that this is the only knowledge they have of this. She indicated there was no set time to assess for pain, they go by the persons non verbal if they look in pain or if they say they are in pain. The Assistant Director of Nursing indicated during interview on 7/10/14 at 3:15 P.M., that nurses should assess and			

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	address pain regardless if a person has a history of addiction to pain medication. The pain control policy dated 7/2005 indicated,"...2. Any Resident complaint of pain will be reported to the nurse promptly, by the staff, The Nurse on Duty is responsible to take immediate action to effectively treat the pain. 3. Pain intensity should be measured with appropriate measurement tool. a. A pain scale of 0-10 (0= no pain, 10= worst pain) should be utilized for Resident...4. Pain will be evaluated on the Pain Assessment Sheet and the Pain Flow Sheet. Pain assessments will be done on admission, quarterly and PRN. a. The Pain Flow sheet will monitor complaints and intensity of pain and document interventions, effectiveness of administered treatments and medication side effect or ineffective interventions. b. Effective or ineffective interventions will be documented one(1) hour on the Pain Flow Sheet...5. Description(s) of pain , nothing Resident's personal words, should be documented including: a. Location of pain area(s) b. Quality, and/or patterns of radiation. c. Onset, duration, and/or precipitating factors. d. Pain management history and effectiveness. e. Effects of pain on daily life-level of impact. f. Resident's pain goal. (What level is acceptable?)			

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	g. Resident's knowledge level of disease process(s) related to pain, medications and/or alternative treatment provided...." There was no documentation on the MAR for May, June, or July related to any numeric pain scale information. There was no pain flow sheet documentation found. A discharge summary from the hospitalization prior to admission on 3/27/14 indicated, "...The family stated he has had prior admits for narcotic withdrawal. His pain is managed by a pain specialist...." There was no documentation found that a pain specialist had been contacted for a referral. A request was made to the Director of Nursing for all documentation related to pain for Resident #8 on 7/10/14 at 4:30 P.M. As of the exit conference on 7/14/14 at 2:30 P.M., no other documentation was provided. 3.1-37(a)			

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ST AUGUSTINE HOME FOR THE AGED	2345 W 86TH ST INDIANAPOLIS, IN 46260

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F000314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. Based on observation, interview and record review, the facility failed to ensure pressure ulcers were assessed, interventions implemented, treatment completed to ensure pressure ulcers did not develop or worsen for 3 of 4 residents reviewed for pressure ulcers. (Residents #12, #14, and #40) Resident #12 pressure ulcer deteriorated from stage II to a stage III without treatment change or positioning. Findings include: 1. On 7/9/14 at 9:15 A.M., Resident #12 was observed lying on her left side and her right heel was lying on the mattress. On 7/9/14 at 10:00 A.M., the resident was observed lying on her left side and her right heel was lying on the mattress. On 7/9/14 at 10:50 A.M., Activities	F000314	To ensure that all care plan treatments are followed and policy and procedure for Skin management/skin care/decubiti/and non sterile dressing changes are carried out by qualified personnel the facility will: Have an in service for all nursing staff, we will go over our policies and procedures at length, handing out copies of each. CNA's are educated to notify the nurse immediately upon finding any red areas. The nurse will perform an assessment of wound, contact the MD for a treatment and notify the wound team. The wound team will assess the wound after notification from the nurse and every week thereafter until healed. The wound team will monitor wound sheets weekly for accuracy and completeness. The wound team or the nurse on duty that sees a change in wound will notify MD of changes or deterioration. During weekly	08/13/2014

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	Assistant #15 entered the resident's room, spoke to her and turned her television on for her. The resident was observed lying on her left side and her right heel was lying on the mattress. On 7/9/14 at 11:00 A.M., the resident was observed lying on her left side and her right heel was lying on the mattress. On 7/9/14 at 12:30 P.M., the resident was lying on her left side and her right heel was lying on the mattress. On 7/10/14 at 3:26 P.M., Resident #12's right buttock area was observed during a dressing change. The right buttock area was observed with an open area with 15% red, 35% yellowish/white slough (stringy, moist, dead and nonvascular tissue in the process of separating from the viable portions of the body) and 50% blackish/brown eschar (thick, leathery and dead tissue that has lost it's own usual properties and biological activity) tissue to the wound bed. Resident #12's record was reviewed on 7/9/14 at 9:52 A.M. Diagnoses included, but were not limited to, decubitus ulcer to the right buttock area, osteoarthrosis, osteoarthritis of the neck, deep vein thrombosis of the right calf and Alzheimer's dementia.		wound team rounds, a monitoring flow sheet will be updated on current status of wound-improving, deteriorating or lack of progress. Skin assessments will be done on admission, quarterly, with significant change, and upon finding any red areas on a resident. Monitoring: For positioning, turning every 2 hours, and floating heels - the nurses will check once per shift for three weeks, then once a day for one month that this is being completed by CNA's for those residents with those orders. Care plan interventions will be monitored for compliance by the unit nurse once per shift x 3 weeks, then once a day for one month for all residents with orders to turn every 2 hours, float heels and reposition back to 30 degree position 30 minutes after meals. Any CNA not in compliance with care plan interventions will be disciplined according to our disciplinary procedures. The ADON will monitor 2 dressing changes by two different nurses on 2 different residents a week times 4 weeks to ensure each nurse is following our policy and procedure for dressing changes. If any non compliance is found, the ADON will re-educate the nurse and have the nurse return demonstrate correct procedure. This will be implemented on 8/13/14 in a compliance monitoring log.	

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The resident's July 2014, Treatment Administration Record recap (Recapitulation) included, but were not limited to the following orders:
7/22/11--Concave mattress.
1/30/14--Float heels while in bed.
7/3/14--Turn every two hours side to side only for decubitus ulcer.

The resident had a Care Plan dated 7/10/14, that addressed the problem she had a Stage III pressure ulcer to her right buttock area. The interventions indicated "7/10/14--Turn resident side to side to maintain pressure off of that area...."

A "Wound Evaluation Flow Sheet" dated 6/20/14, had an "X" marked in the box for pressure ulcer for the wound type. The flow sheet indicated the resident had a wound to her right buttock that was staged as a Stage II wound on 6/20/14. The measurement was 0.3 x 0.1 x 0.0 cm (centimeters). The drainage amount was scant and was serosanguineous (a drainage mixed with serous fluid and blood) with a thin consistency. No odor from the wound. The tissue type was 100% epithelial tissue. The periwound (skin around the wound) margins was intact and the surrounding tissue was intact. The current pressure ulcer treatment was Carraguaze and a dressing

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	that was initiated on 6/20/14. The current preventative interventions were an air mattress and turning the resident every two hours and was initiated on 6/20/14. The wound status was a new area. A "Wound Evaluation Flow Sheet" dated 6/20/14, had an "X" marked in the box for pressure ulcer for the wound type. The flow sheet indicated the resident had a wound to her right buttock that was staged as a Stage II wound on 6/27/14. The measurement was 2.0 x 2.0 x 0.1 cm (centimeters). The drainage amount was moderate and was serosanguineous with a thin consistency. No odor from the wound. The tissue type was 100% epithelial tissue. The periwound (skin around the wound) margins was intact and the surrounding tissue was intact. The current pressure ulcer treatment was Carraguaze and a dressing every day that was initiated on 6/20/14. The current preventative interventions were an air mattress and turning the resident every two hours and was initiated on 6/20/14. The wound status indicated it was deteriorating. A "Wound Evaluation Flow Sheet" dated 6/20/14, had an "X" marked in the box for pressure ulcer for the wound type. The flow sheet indicated the resident had			

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	a wound to her right buttock that was staged as a Stage III wound on 7/3/14. The measurement was 8.0 x 7.0 x 0.2 cm (centimeters). The drainage amount was moderate and was serosanguineous with a thin consistency. No odor from the wound. The tissue type was 35% slough (stringy, moist, dead and nonvascular tissue in the process of seperating from the viable portions of the body) , 50% eschar (thick, leathery and dead tissue that has lost it's own usual properties and biological activity) and 15% granulation (red and viable tissue). The periwound (skin around the wound) margins was macerated (moist) and the surrounding tissue was pink and intact. The current pressure ulcer treatment was Carraguaze and a dressing that was initiated on 6/20/14. The doctor was notified for a treatment change and a referral to the wound clinic on 7/3/14 . The current preventative interventions were an air mattress and turning the resident every two hours and was initiated on 6/20/14. The wound status was deteriorating. During an interview on 7/7/14 at 3:43 P.M., LPN #9 indicated the resident acquired her Stage II pressure ulcer to her right buttock area on 6/20/14 and on 7/3/14 it was a Stage III that measured 8.0 x 7.0 x 0.2 cm.			

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	The Physician progress notes indicated the resident had developed other pressure ulcers in the following areas around these approximate dates: 8/11/13--Indicated the resident developed an open area to her left buttocks and Zinc Oxide as needed every four hours was ordered. 10/23/13--Indicated she developed a "small" ulcer on her left heel that was "soft and mushy." The treatment was a Betadine soak dressing and the staff was to avoid pressure to the resident's heels. 2/19/14--Indicated the resident had a "small" pressure ulcer on her buttocks and ankle. The treatment was a Duoderm dressing (a dressing that provides a moist healing environment that allows clean wounds to heal and wounds with dead tissue to debride naturally). 4/23/14--Indicated she had a "small" pressure ulcer to her toes that was slow healing. The progress notes indicated the following: 1/31/14--Indicated the resident had a new unopened "pea-sized" reddened area on the right buttock. 2/18/14--Indicated the resident had Duoderm ordered to her right buttock to be changed every 72 hours. 4/15/14--Indicated the resident had a "pea-sized" open area to her right			

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	buttock. A "Wound Evaluation Flow Sheet" dated 10/21/13, had an "X" marked in the box for pressure ulcer indicated the resident had a facility acquired suspected deep tissue injury to her left heel that measured 0.75 x 0.75 x 0.0 cm. The wound margins were brown and the surrounding tissue was brown. Current Preventative Interventions were to elevate the heel off the bed, but the area lacked a date that the intervention was initiated. The form lacked a current treatment for this wound. The left heel wound was healed on 12/18/13. A "Wound Evaluation Flow Sheet" dated 2/18/14, indicated the resident had a facility acquired wound to her right buttocks that measured 0.5 x 0.3 x 0.1 cm. The form lacked current preventative interventions with a date that they were initiated. The treatment was Duoderm and Zinc Oxide and it was initiated on 2/18/14. The wound was healed on 3/2/14. A "Wound Evaluation Flow Sheet" dated 4/19/14, had an "X" marked in the box for pressure ulcer indicated the resident had a facility Stage II that measured 0.5 x 0.5 x 0.0 cm. The treatment was Duoderm applied every 72 hours and it			

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	was initiated on 4/19/14. The current preventative interventions were turning and repositioning, but the form lacked a date that these interventions were initiated. During an interview on 7/9/14 at 12:30 P.M., CNA #7 indicated this resident was her responsibility to provide care to for the shift and she was turned at 9:00 A.M. She indicated she had not turned her as of yet, because she had not had time, because she had been busy taking care of her other residents. CNA #7 indicated the back up plan when she got behind in her work load was to ask one of the other CNA's to help her if they were not busy. She indicated if the other CNA's were busy then she was to call one of her supervisors to come and help her. She indicated she had not asked anyone for help. She had just tried to "catch up." During an interview on 7/9/14 at 1:50 P.M., LPN #1 indicated the resident's right heel "was a little pink, but it was not mushy" She indicated she had not realized that the resident had not been turned for three and a half hours. During an interview on 7/9/14 at 5:50 P.M., the DoN (Director of Nursing) indicated the residents were to be turned every two hours.			

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	2. On 7/9/14 at 9:50 A.M., Resident #40 was observed lying on her back with a pillow propped at the right side of her back and she was sitting at a 90 degree angle. The resident's bilateral heels were lying on the mattress. On 7/9/14 at 10:36 A.M., LPN #1 went into the resident's room and obtained her vital signs. The resident was observed lying on her back with a pillow propped at the right side of her back and she was sitting at a 90 degree angle. The resident's bilateral heels were lying on the mattress. On 7/9/14 at 10:40 A.M., the Activities Assistant #15 went into the resident's room and said "Good Morning" to her then left the room. The resident was observed lying on her back with a pillow propped at the right side of her back and she was sitting at a 90 degree angle. The resident's bilateral heels were lying on the mattress. On 7/9/14 at 11:35 A.M., CNA #7 was observed entering the resident's room to give her a bath. The resident was observed lying on her on her back with a pillow propped at the right side of her back and she was sitting at a 90 degree angle. The resident's bilateral heels were			

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	lying on the mattress. The resident's bilateral heels were observed to be red and felt mushy. On 7/9/14 at 2:26 P.M., LPN #1 was observed changing the resident's dressing to her pressure ulcer to her coccyx. LPN #1 placed the dressing supplies, including scissors that were in the resident's dresser drawer on her bare bedside table. She and CNA #14, who was assisting her washed their hands. LPN #1 removed the old dressing and packing from the coccyx wound and she placed both of them in the dirty chux that had urine and stool on it and rolled them into the chux. She did not change her gloves. She cleansed the inside and the outside of the wound with sterile water with two folded 4 x 4 guazes. She packed the open wound with Silver Alginate packing strip that was approximately 1 inch in width with the end of a sterile applicator (a long cotton q-tip). She was not observed to cleanse the scissors before she cut the Silver Alginate packing strip. She covered the wound with a 2 x 2 foam island dressing. She threw her trash away. She gathered the dressing supplies and scissors and placed them back in the resident's dresser drawer and washed her hands. Resident #40's record was reviewed on 7/9/14 at 4:00 P.M. Diagnosis included,			

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	but were not limited to, vascular dementia with delusions, severe progressive dementia, legally blind, Urinary tract infection , Spinal stenosis, osteoarthritis, Stage 4 pressure ulcer to the coccyx area and incontinence. The resident's July 2014, Treatment Administration Record recap (Recapitulation) included, but were not limited to, the following orders: 11/13/13--Cleanse coccyx wound with purified water or Normal Saline prior to applying clean dressing. Do not scrub or use excessive force, pat dry, pack the wound loosely with Silver Alginate packing (antimicrobial guaze packing used to pack wounds, aided in preventing infections and allowed wounds to heal from the inside to the outside) and fill all the dead space. Leave the tail of the packing material to help with the removal on the side of the wound bed. If on the next dressing change the dressing is dry, moisten it with purified water or Normal Saline prior to the removal. Cover the wound with bordered foam. Cover the open area to the periwound. No order date--Float heels A "Discharge Instruction Details" sheet indicated, Wound Clinic orders dated 4/2/14, indicated "...offload heels-no			

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	pressure to heels...Do not elevate HOB (head of bed) over 30 degrees and limit time spent up in w/c (wheelchair) to decrease friction and pressure to wounded areas..." The resident had a Care Plan with a revision date of 5/9/14, that addressed the problem she had a Stage IV pressure ulcer to her coccyx area. Interventions indicated "...3/22/13--Treatment as ordered...5/16/13--Reposition resident to maintain pressure off of area where ulcer is present...." A "Wound Evaluation Flow Sheet" dated 3/12/13, indicated the resident had a facility acquired Stage IV pressure ulcer to her coccyx/sacrum area. The sheet indicated the wound developed on 2/27/13. The wound measured 4.4 x 3.0 x 0.3 cm . The wound had serosanguineous drainage and it was thin in consistency with scant foul odor. The wound bed was 20% pink tissue and 80% dark red tissue. The periwound was red and the surrounding tissue was intact. The current treatment was Carraguaze hydrogel dressing. Wound status was worse. A "Wound Evaluation Flow Sheet" dated 6/2/14, indicated the resident had a facility acquired Stage IV pressure ulcer			

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	to her coccyx/sacrum area. The sheet indicated the wound developed on 2/20/13. The wound measured 3.0 x 2.0 x 3.0 cm with 11 o'clock to 1 o' clock undermining (the rim of the pressure ulcer was eroding away) tissue . The wound had serosanguineous drainage and it was thin in consistency with scant foul odor. The wound bed was red tissue. The wound margins were defined with the surrounding tissue intact. The current treatment was Silver Alginate packing strip, then cover with foam dressing and the treatment was initiated on 11/13/13. Wound Status: Not healing A "Wound Evaluation Flow Sheet" dated 7/7/14, indicated the resident had a facility acquired Stage IV pressure ulcer to her coccyx/sacrum area. The wound developed on 2/20/13. The wound measured 4.0 x 2.5 x 3.0 cm with 12 o' clock to 12 o'clock undermining tissue . The wound had serosanguineous drainage thin in consistency and a scant foul smelling odor. The wound bed was red-granulation tissue and less than 25% slough. The wound margins were defined and the surrounding tissues were intact. The current treatment was silver alginate, cover with foam and change the dressing every other day and as needed for soilage. The treatment was initiated on 11/13/13. Wound status was not healing.			

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The resident's coccyx pressure ulcer treatment had not been changed since 11/13/13 even though the wound was not healing.

No wound sheets prior to 3/12/13 was provided by the end of the exit conference on 7/14/14.

During an interview on 7/9/14 at 11:35 A.M., CNA #7 indicated the resident was lying on her back and she placed a pillow on the right side of her to relieve some of the pressure off her bottom when she was lying on her back. She indicated the resident's heels were to be floated off the bed with pillows and the resident's heels were lying on the mattress.

During an interview on 7/11/14 at 4:00 P.M., the DoN (Director of Nursing) indicated the HOB should not have been elevated in the 90 degree position.

A current policy titled "DRESSING, NON STERILE" dated 07/2005, provided by the DoN on 7/9/14 at 2:45 P.M., indicated "...PURPOSE: To protect, to absorb drainage and to promote healing of the wound... 5. Remove soiled dressing and place in trash bag... 6. Wash hands and apply new gloves. 7. Cleanse wound and

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	surrounding tissue with prescribed solution and dry with guaze...." 3. The closed clinical record for Resident #14 was reviewed on 7/9/14 at 2:44 P.M. Diagnoses included, but were not limited to, hypertension, transient cerebral ischemia, stricture of artery, depressive disorder, and hypothyroidism, The resident was originally admitted to the health care section of the facility on 2/14/14, following a fall in her independent apartment that resulted in a fractured hip. She was discharged again to hospital on 2/27/14 for a gastrointestinal bleed from a perforated duodenal ulcer, and was readmitted to the facility on 3/2/14. She expired on 3/7/14 at 4:35 P.M. A progress note, dated 2/14/14, indicated "Arrived on unit... Skin assessment shows bruises on arms and legs post IV and fall. Bottom is red." There were no other progress notes from 2/14 to discharge on 2/27/14 related to the red bottom or other skin issues. On 2/21/14, the physician gave an order for "Duoderm to coccyx, change every 72 hours." DuoDerm is an opaque hydrocolloid dressing used to cover and treat superficial, partial, and full thickness pressure ulcers and other skin			

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	issues. A "Skin Assessment," dated 2/14/14 and completed by a unit nurse, indicated "Home from the hospital this eve. Has bruises on legs and arms post IV and fall. Bottom red." There was no additional descriptive information related to the red bottom. A "Skin Assessment," dated 3/2/14 and completed by the same unit nurse, indicated the resident had no pressure ulcers, with pale, normal/warm, and dry skin. There was no additional descriptive information related to the status of the resident's skin. The March, 2014 MAR (Medication Administration Record) had nurse initials documenting the DuoDerm was applied on 3/1 and 3/5/14. During an interview on 7/10/14 at 2:09 P.M., the Director of Nursing indicated the "Skin Assessments" documentation was all that she was able to locate, related to the resident's skin assessments and condition. The Admission MDS was completed on 3/3/14, with an Assessment Reference Date (ARD--the last day of the observation period) of 2/27/14. Section M, for assessment of the skin, covered a time frame of 7 days prior to the ARD.			

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	For Resident #14, the time period would have been from 2/20 to 2/27/14. The coding at this section indicated the resident was at risk for developing a pressure ulcer, had no current unhealed pressure ulcer at Stage 1 or higher. had a surgical wound and skin tears. There was no identification of any skin issue that would have required a DuoDerm skin treatment beginning on 2/21/14. In an interview on 7/11/14 at 9:00 A.M. the MDS Coordinator indicated she did not see or examine the resident's bottom upon admission (2/14/14), and none of the nurses had said anything to her about the resident's "red bottom." She took the order for the Duoderm on 2/21/14, and saw the area either later the same day or the next day. She indicated she thought the coccyx area may "just have been excoriated," but she could not recall for sure. She indicated the nurses completing the computer "Skin Assessment" forms should use Section 1 to describe any areas of a resident's body where the skin was altered (rashes, scars, skin tears, abrasions, bruises, surgical incisions, etc.) The MDS Coordinator indicated a barrier cream was the treatment of choice for skin excoriation. 3.1-40(a)(1)			

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	3.1-40(a)(2)			
F000315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. Based on observation, interview and record review, the facility failed to ensure perineal care and catheter care was provided in a manner to prevent the possibility of infection for 1 of 3 residents observed for perineal (peri) and catheter care. (Resident #40) Findings include: On 7/9/14 at 11:35 A.M., CNA #7 was observed giving Resident #40 peri care. She was observed washing the resident's perineal area from the back to the front on the outside of the labia, then she washed underneath the resident's abdominal fold using the same area of the wash cloth. CNA # 7 washed the front of the resident's perineal area from front to back washing from the meatus area up	F000315	All all nursing inservice will be conducted reviewing all policies and procedures for catheter care and pericare to prevent and reduce UTI's. Policy and Procedures for these have been updated and assign the CNA's to perform catheter care every shift and peri-care every shift and as needed after incontinent episodes. Catheter and peri-care will be demonstrated by an RN during the inservice. Monitoring : Nurses will monitor each CNA doing catheter or peri care once a month x 2 months. A compliance monitoring log will be implemented for documentation and each CNA checked off as they complete proper peri-care and catheter care. CNA's will be re-educated by nursing staff if needed on proper procedures.	08/13/2014

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	towards the abdomen, then she washed the resident from the back to the front on the outside of the labia area washing under the resident's abdominal fold using the same area of the wash cloth. CNA #7 was observed rinsing the resident's perineal area from the back to the front on the outside of the labia area, then under the resident's abdominal fold with the same area of the wash cloth. After she rinsed the abdominal fold, CNA #7 rinsed back to front on the outside of the labia area, then she rinsed the front of the resident's perineal area with the same area of the wash cloth. CNA #7 patted the resident dry with a bath towel by starting from the bottom of the outside of the labia, by the meatus area and going up under the abdominal fold, then she patted the resident dry back down to the labia and back up to the abdominal fold. CNA #7 and CNA #8 was observed turning the resident onto her right side. CNA #7 wiped the liquid stool from the resident's anal area with the paper chux pad that had been between her legs and was saturated with urine, which had leaked from her catheter. CNA #7 was observed washing the resident's anal area, then washed both her buttocks. She rinsed the resident's anal area, then her buttocks. She dried the resident's anal area, then her buttocks. CNA #7 was not			

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	observed providing catheter care to Resident #40 while providing peri care. The resident's record was reviewed on 7/9/14 at 4:00 P.M. Diagnosis included, but were not limited to, Vascular dementia with delusions, severe progressive dementia, legally blind, urinary tract infections , Spinal stenosis, osteoarthritis, delirium secondary to recent urinary tract infection, stage 4 pressure ulcer to coccyx and incontinence. A Physicians progress note dated 8/14/13, indicated the resident had a UTI (urinary tract infection) that was treated with Tobramycin (an antibiotic). A Physicians progress note dated 3/19/14, indicated the resident had frequent urinary tract infections (UTI) from "having a chronic indwelling Foley catheter to help a decubitus heal." He indicated she currently had a (UTI) at the time of this note and was being treated with Macrobid (an antibiotic). The resident's Quarterly MDS (Minimum Data Set) assessment dated 5/28/14, indicated her Cognitive Skills for Daily Decision Making were moderately impaired, which indicated her decisions were poor and cues and supervision were			

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	required. The resident's functional status indicated she was totally dependent with two person physical assistance needed for bathing. The resident had a July 2014, Treatment Administration Record recap (recapitulation) included, but was not limited to the following: 1/30/14--Catheter care every shift. During an interview on 7/9/14 at 12:30 P.M., CNA #7 indicated she gave female residents peri care by washing from the front to the back. She indicated the reason she did not flex the resident's legs and open them as wide as possible while providing peri care was due to the resident's legs were hard to get open and she cried whenever her legs were opened. She indicated she thought she had provided this resident with peri care by washing her perineal area from front to back. She indicated she did not do catheter care because "I have not performed catheter care in the 30 years that I have been a CNA because I was not taught to do that." She indicated the nurses at this facility have told the CNA's "Not to mess with the catheters because we will pull on them and that is why they leak." She indicated she thought the nurses did the			

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	catheter care. During an interview on 7/9/14 at 2:45 P.M., LPN #1 indicated the CNA's were to provide catheter care for residents during baths and with incontinent episodes. During an interview on 7/9/14 at 4:00 P.M., the DoN (Director of Nursing) indicated that "Nursing Personnel" according to the "Urinary Catheter Care Policy and Procedure" indicated the Nurses or the CNA's either one could provide catheter care to the residents with catheters. During an interview on 7/9/14 at 5:50 P.M., the DoN indicated this resident should have had catheter care provided by CNA #7 during her bath and during any incontinent care by all nursing staff. A current policy dated 07/2005, titled "PERINEAL CARE" provided by the DoN on 7/9/14 at 2:45 P.M., indicated "...PROCEDURES: ...7. Use toilet tissue to remove stool if present. 8. Spray perineal area with peri wash. Rinsing is not necessary. For females, wipe center of vulva from top downward, observe for any abnormalities, and inform the charge nurse as needed. 9. If soap and water are used, wash female from top of vulva			

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	downward and rinse...10. If Resident has a catheter also wash catheter from point of entry downward. Use a clean part of the wash cloth each time...." A current policy dated 07/2005, titled "CATHETER CARE, URINARY" provided by the DoN on 7/9/14 at 2:45 P.M., indicated " POLICY: It is the responsibility of all nursing personnel to provide safe and effective catheter care...PROCEDURE: ...12. Provide routine peri care for Residents with a catheter to assist in the prevention of infectious organisms traveling up the catheter into the bladder. a. Position for catheterization. b. Starting proximally (at Meatus) cleanse the catheter with perineal spray or soap and water; wipe away from the meatus...." 3.1-41(2)			
F000329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose			

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	should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. Based on interview and record review, the facility failed to keep a resident from receiving a medication that was unnecessary after psychotic symptoms subsided for 2 of 5 residents reviewed for unnecessary medications in a sample of 22. (Resident # 28 & Resident #31) Findings include : 1. On 7/9/14 at 10 A.M. the record review for Resident #28 was completed. Diagnoses included, but were not limited to, diabetes, high cholesterol, PVD (peripheral vascular disease), acid reflux, acute kidney failure, depressive disorder, acute kidney failure,and dementia. The progress notes indicated: Social Service progress note dated 4/22/14 indicated, "...Resident appears	F000329	For the residents with possible unnecessary medication, the nurses and CNA's will review the guidelines for documentation of behaviors. DON has been systematically reducing the anti psychotic medications on residents as appropriate, however a new plan will be put into place to notify the physician/nurse practitioner within 4 weeks of a resident with no behaviors. The psychiatric nurse practitioner will then determine appropriate medication. The DON does maintain a grid on each resident on a psychotropic medication. This grid includes medication dose, frequency, diagnosis, behaviors, improvements or increases in behaviors, doctors orders, and when the resident was last seen and the followup appointment. Each week the behavior committee meets to review residents with behaviors. Those on psychotropic	08/13/2014

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	more lethargic and sleepy; displaying at times an inability to feed herself in the dining room. Nursing will discuss the possibly with psychiatric doctor of another gradual dose reduction with her psychotropic medications. No other concerns were discussed at this time...." The physician orders indicated: 2/20/14- Risperidone 0.25 milligrams every day dementia associated with behavior symptoms. The behavior tracking sheet indicated behaviors were: 1. Physical aggression 2. Verbal aggression 3. Property destruction 4. Noncompliance 5. Psychosis 6. Sexually inappropriate The behavior tracking sheets dated November 2013 through July 2014 were blank which the Social Service Director indicated meant that there had been no behaviors. 2. On 7/12/14 at 2:00 P.M., the record review for Resident #31 was completed. Diagnoses included, but were not limited to, dementia with behavioral disturbance, depression, and hypothyroidism.		medications will be reviewed every week at the meeting. We will have our medical records consultant review not less then 2 residents on psychotropic medications with each of her visits. The pharmacist does an audit every month reviewing all resident medications, they then suggest a GDR or discontinuation of unnecessary drugs if appropriate. Our psychiatric nurse practitioner comes monthly to see residents with the DON or ADON and she meets with the residents to determine if prescribed medication is appropriate or changes need to be made. The NP also goes over the pharmacy recommendations. Monitoring: The behavior committee will review residents on anti psychotic medications every week, this will be documented on the behavior committee weekly monitoring sheet. The NP will be notified of behaviors that need medical attention including no behaviors in the last 4 weeks. The NP will make the necessary changes in the residents medications. Our medical records consultant will review not less than 2 residents with each of her visits on a quarterly basis. After each visit she sends a summary of whom she reviewed, her next visit is 8/18/14.	

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The physician orders indicated:
2/20/14 -Risperdal 0.25 milligrams by mouth twice daily. Diagnosis: Paranoia.

The physician's progress notes dated from January 2014 through July 2014, indicated no episodes of paranoia.

The psychiatrist progress notes indicated:
6/26/14-"...has been on Risperdal 0.25 milligrams daily due to an episode of paranoia. Today is drowsy but arousable. Speaks very little, but responds non-verbally- smiles appropriately. Has had no recent behaviors that would indicate paranoid ideation, hallucinations, or delusions, sleep appetite are ok...
2/20/14- reviewed meds, staff reported patient refuses med at times, little bit paranoid, but behavior got lot better. Nursing says saw tremors on and off. Patient to have GDR (gradual dose reduction) for Risperdal. Patient denied being depressed and no problem with sleep or appetite and no negative symptoms reported...
10/29/13- Indicated patient improved slightly, still some refusal take her meds and some tearful episodes. Nursing reports whenever her son comes he tells her not to take her medications. Patient seem more irritable after visit with son. Patient complaining of being concerned,

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	worried and anxious. Indicated no hallucinations. Dementia and depression were listed under assessment and document behavior. Indicated Psychotropic meds reviewed. Dosage reduction is/ is not(is not was circled) indicated at this time. reason: Risk of relapse is to great, current benefits of treatment outweigh the risks at this time. Underline risk of relapse and risks... 8/27/13 -patient seen today staff reported no behavior, patient has been stable. was scheduled a gradual dose reduction of psychotropics. Patient says she feels sad sometimes thinking about her children. Says she she prayed Lord in difficult times...hallucinations-none. Risperdal 0.25 mg po BID...Continue other meds...." The behavior tracking sheet had the following behaviors: 1)Physical aggression 2) Verbal aggression 3) Property destruction 4) Noncompliance 5) Psychosis 6) sexually inappropriate. The behavior tracking sheets for November 2013 through July 2014 were blank on each page. On 7/11/14 at 1:45 P.M., the SSD indicated there were no behavior tracking logs prior to November 2013. A progress note dated 2/22/14, the			

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	resident was observed to have yelling and moaning during breakfast number of times noted and when. Multiple times throughout AM meal. Intervention: Redirection attempted : Staff talked with resident in attempt to find out why she was moaning. No complaints of pain voiced. Resident taken to bathroom and then to nurses station. Intervention was effective, behavior altered. The progress notes indicated the physician saw her on 7/9/14 no new orders. On 7/11/14 at 1:35 P.M., the Director of Nursing indicated she had been working very hard on getting all of the resident's medication reduced. She indicated Resident #28 and Resident #31 had paranoia in the past, but had not displayed it for a while. She further indicated Resident #31 had been on Risperdal 0.25 milligrams BID and was now on Risperdal 0.25 milligrams daily. She indicated the resident had past behaviors of paranoia, but indicated the documentation since August 2013 does not reflect any paranoid behavior. 3.1-48(a)(4)			
F000371 SS=F	483.35(i) FOOD PROCURE,			

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	STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview and record review, the facility failed to ensure foods were maintained in a sanitary manner in the kitchen and the facility failed to ensure staff and volunteers, serving food during meals, used disposable gloves in an appropriate manner to prevent cross-contamination. This deficient practice had the potential to affect 40 of 40 residents in the facility receiving food from the kitchen. Findings include: On 7/7/14 at 9:33 A.M., the tour of the kitchen was started with the Dietary Manager and the Dietary Assistant in attendance. 1. Five pudding type food items that were yellow in color were observed sitting on the top shelf on top of pies, in the produce cooler. The pudding type food items were not labeled. The Dietary Manager and the Dietary Assistant indicated at this time the pudding type food items were pie purées	F000371	Dietary will conduct an inservice for all kitchen and dietary employees and volunteers on food storage, dating and labeling, and procedure for dented and bulging cans. Dietary manager or assistant will return Sysco cans for credit that are bulging or dented. GFS cans will be discarded. Signs will be posted in food storage areas with reminders to label and date items. Dented can reminders to be posted outside dry storage room. Reminder to seal and date open items will be posted on cabinets and refrigerators. An inservice on cross contamination and proper glove use will also be conducted. Instructor will educate pantry aides and volunteers when to use and discard food service gloves as well as the basics of preventing cross contamintation. Signs will be posted in the pantry to remind pantry aides and volunteers when and how gloves need to be changed and handwashing done. This will be implemented by 8/13/14. The dietary manager/dietarty assistant will ensure that foods are stored in a sanitary manner by conductine a focused sanitation check of 12	08/13/2014

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	15E245	A. BUILDING 00 B. WING	07/14/2014

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	that were made yesterday by Cook #6. The Dietary Manager nor the Dietary Assistant could identify what type of pie purées they were because they indicated they had not made them, but they should have been labeled with a date and the type of pie purées. 2. Twelve pies were observed on the top shelf in the produce cooler. The pies were not dated with a date when they were pulled from the freezer to thaw in the produce cooler. During an interview at this time, the Dietary Assistant indicated there was one Strawberry Rhubarb pie, seven Blueberry pies, two diet Cherry pies, one diet Apple pies and two Apple pies sitting on the top shelf. He indicated the pies were taken out yesterday to thaw for lunch today and they should have been dated with the date they were removed from the freezer to thaw. 3. These spice bottles was observed in the spice cabinet and they did not have an open date and/or the lids were not closed: Ground Basil spice--12 ounces Garlic powder spice--21 ounces Ground Thyme spice--12 ounces Taco seasoning--21 ounces Ground Cinnamon spice--15 ounces Onion powder spice--19 ounces		occasions over a 30 days period beginning 8/12/14. The focus of the checks will be on correct handling of dented cans and correct labeling of food products, correct dating of food products, and proper sealing of food containment (see attached form, food storage survey) Monitoring : Monitoring of proper food storage will continue through weekly sanitation checks completed and documented by the Dietary Manager and/or dietary assistant on the monitoring flow sheet. The unit manager will ensure that food is being served in a sanitary manner by conducting one (1) meal service sanitation survey of each meal of the week over a 60 day period beginning August 13, 2014. This will be a total of 21 monitoring's of meals over a 60 day period. The unit manager may designate another trained staff member or the consultant RD to survey meals if he/she is unable to do so. They will use the form provided in this plan, which will be faxed to ISBH the same day the POC is mailed. Monitoring of proper meal service will continue through quarterly surveys conducted by the consultant RD.	

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	Rubbed Sage spice-6 ounces During an interview at this time, the Dietary Manager indicated the spice bottles should have had an open date and should have been closed tightly. 4. An eight pound chicken base container and an eight pound beef base container were observed sitting on a shelf in the dairy cooler with no open dates. The tops of the lids to the containers did not fit snugly on the containers, but rather were just resting on the tops of the containers. A 16 ounce low sodium beef base lid was partially off the top of the container and there was no open date on the container. During an interview at this time, the Dietary Assistant indicated the meat base containers should have had an open date on the containers and the lids should have been tightly placed on top of the containers. 5. In the dry storage area, these cans were observed to be dented: 3--104 ounces Mandarin Orange segments 1--107 ounces Crushed Pineapple 1--99 ounces Shredded Sauerkraut During an interview at this time, the			

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	Dietary Assistant indicated the facility did not use dented cans. He indicated he notified the company he had dented cans and he received a credit for the dented cans then he threw the cans in the trash. A current policy dated 01/2009, titled "RECEPTION AND USE OF FOOD ITEMS AND THE PREVENTION OF FOOD BORNE ILLNESSES" was provided by the Dietary Manager on 7/11/14 at 9:54 A.M., indicated "...PURPOSE: To ensure quality food products for use for the Residents' meals. PROCEDURE...2. Specific Procedures for Various Food Items: ... b. If Canned Goods are dented or bulging, they must be discarded...." 2. The following was observed in the third floor kitchenette and dining room during the lunch meal on 7/7/14 at 12:02 P.M.: Dietary Aide #3 was observed to have disposable gloves on. She indicated at that time she had checked the food temperatures. She used her gloved finger to point to the temperatures by placing her finger on a paper, which was on a clipboard. Using the same gloves, Dietary Aide #3 touched door handles, drawer knobs, and other equipment in the kitchenette.			

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	Using the same gloves, she pushed a two-tiered cart, with open pans of food, from the kitchenette out into the middle of the dining room. She used tongs to pick up a piece of chicken from one pan, and carry it half-way across room to put on a resident's plate. Her other hand (with the same glove on) was positioned about 2 inches underneath the chicken as she carried it across the room. After placing the chicken on the plate, Dietary Aide #3 picked up the plate with her gloved hand, positioning her hand with her thumb on the inside rim at the edge, and carried it back to the cart. At the cart, she placed vegetables and potatoes on the plate, handling the ladles and other utensils on the cart. Taking it back to the resident, she held the plate with her thumb on the inside rim/food surface. She was observed to repeat this process when serving 3 other residents. Mid-way through the meal service, Dietary Aide #3 was observed coughing twice into her bare arm at the wrist, just above top of the glove. The following was observed in the third floor kitchenette and dining room during the lunch meal on 7/9/14 at 12:06 P.M.: An unidentified volunteer was observed to have on disposable gloves, and was assisting other staff to set out utensils and			

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	equipment. She touched drawer knobs, and other equipment handles. At 12:12 P.M., she went to the sink in the kitchenette. She turned on the taps with her gloved hands, rinsed the finger tips of each gloved hand, turned the water off with her gloved hands, and then got paper towel to dry the gloves. Hospitality Intern #4 was observed to have disposable gloves on, and was opening cart doors, refrigerator doors, drawers, and handling pans and dishes. At 12:14 P.M., with the same gloves on, she proceeded to check the temperatures of the food in the pans, using a sanitizing wipe to clean the thermometer. At 12:15 P.M., with the same gloves still on, the aide was observed to bend over and pick up a small piece of paper off of floor, and then reach into a basket for a sanitizing wipe packet. She then went to the sink, turned on the taps with her gloved hands, washed her gloved hands, turned off the taps with the same gloved hands, and obtained a paper towel to dry the gloves. She was observed to obtain a knife and spoon from a drawer, and put the spoon into a pan of food. She was observed to dish up food from pans on cart in center of dining room, holding the plates with thumb on the inside rim. Dietary Aide #3 was observed to change			

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	her gloves one time, but afterward was then touching pans, door and drawer handles. She was observed to use tongs to carry a baked potato over to table and place on a resident's plate, then pick up the plate, holding it with her thumb on the inside of the rim, to carry over to the cart to put the rest of the food on it. During an interview on 7/9/14 at 12:20 P.M.,, the Dietary Manager indicated staff should have been changing their gloves after handling equipment. She indicated she thought the person overseeing the meal service that day (Hospitality Intern #4) was a volunteer, and that she (the DTM) had no over-sight into the training of volunteers working for Food Service. The "Retail Food Establishment Sanitation Requirements," Title 410 IAC 7-24, effective November 13, 2004, includes the rule for "Glove Use" as follows: "Sec. 246. (a) If used, single-use gloves shall be: (1) used for only one (1) task, such as working with ready-to-eat food or with raw animal food; (2) used for no other purpose; and (3) discarded when: (A) damaged or soiled; or (B) interruptions occur in the operation...."			

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	3.1-21(g)(3) 3.1-21(i)(2)			
R000000				
	The following residential findings were cited in accordance with 410 IAC 16.2-5	R000000		
R000154	410 IAC 16.2-5-1.5(k) Sanitation and Safety Standards - Deficiency (k) The facility shall keep all kitchens, kitchen areas, common dining areas, equipment, and utensils clean, free from litter and rubbish, and maintained in good repair in accordance with 410 IAC 7-24. Based on observation, interview and record review, the facility failed to ensure foods were maintained in a sanitary manner in the kitchen. This deficient practice had the potential to affect 22 of 22 residents in the facility receiving food from the kitchen. Findings include: On 7/7/14 at 9:33 A.M., the tour of the kitchen was started with the Dietary Manager and the Dietary Assistant in attendance. 1. Five pudding type food items that were yellow in color were observed sitting on the top shelf on top of pies, in the produce cooler. The pudding type food items were not labeled.	R000154	Dietary will conduct an inservice for all kitchenand dietary employees, and Volunteers; Inservice: Food Storage, Dating and Labeling; Set dented/bulging cans ontable outside dietary managers office. DietaryManager or Assistant will return SYSCO cans for credit, GFS cans will be discarded. Signage:Reminders to label and date items posted in foodstorage areas. Dented can reminder to be posted outside dry storage room. Reminder to sealand date opened items to be posted on cabinets.Cross-contamination/Improper Glove Use:Inservice for proper glove use; Instructor will educate pantry aides and volunteers when to use and discard food service gloves as well as thebasics of preventing cross-comtamination.Signage: Will be posgted in the pantry to	08/13/2014

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	The Dietary Manager and the Dietary Assistant indicated at this time the pudding type food items were pie purées that were made yesterday by Cook #6. The Dietary Manager nor the Dietary Assistant could identify what type of pie purées they were because they indicated they had not made them, but they should have been labeled with a date and the type of pie purées. 2. Twelve pies were observed on the top shelf in the produce cooler. The pies were not dated with a date when they were pulled from the freezer to thaw in the produce cooler. During an interview at this time, the Dietary Assistant indicated there was one Strawberry Rhubarb pie, seven Blueberry pies, two diet Cherry pies, one diet Apple pies and two Apple pies sitting on the top shelf. He indicated the pies were taken out yesterday to thaw for lunch today and they should have been dated with the date they were removed from the freezer to thaw. 3. These spice bottles was observed in the spice cabinet and they did not have an open date and/or the lids were not closed: Ground Basil spice--12 ounces Garlic powder spice--21 ounces		remind pantry aides and volunteers when and how gloves nees to be changedThis will be implemented by August 13, 2014All inservice paper work will be mailed to ISBHwhen completed.	

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	Ground Thyme spice--12 ounces Taco seasoning--21 ounces Ground Cinnamon spice--15 ounces Onion powder spice--19 ounces Rubbed Sage spice-6 ounces During an interview at this time, the Dietary Manager indicated the spice bottles should have had an open date and should have been closed tightly. 4. An eight pound chicken base container and an eight pound beef base container were observed sitting on a shelf in the dairy cooler with no open dates. The tops of the lids to the containers did not fit snugly on the containers, but rather were just resting on the tops of the containers. A 16 ounce low sodium beef base lid was partially off the top of the container and there was no open date on the container. During an interview at this time, the Dietary Assistant indicated the meat base containers should have had an open date on the containers and the lids should have been tightly placed on top of the containers. 5. In the dry storage area, these cans were observed to be dented: 3--104 ounces Mandarin Orange segments			

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	1--107 ounces Crushed Pineapple 1--99 ounces Shredded Sauerkraut During an interview at this time, the Dietary Assistant indicated the facility did not use dented cans. He indicated he notified the company he had dented cans and he received a credit for the dented cans then he threw the cans in the trash. A current policy dated 01/2009, titled "RECEPTION AND USE OF FOOD ITEMS AND THE PREVENTION OF FOOD BORNE ILLNESSES" was provided by the Dietary Manager on 7/11/14 at 9:54 A.M., indicated "...PURPOSE: To ensure quality food products for use for the Residents' meals. PROCEDURE...2. Specific Procedures for Various Food Items: ... b. If Canned Goods are dented or bulging, they must be discarded...."			